Kaiser Permanente Settles Medicare Fraud Claims for $556 Million

The Justice Department and whistle-blowers accused the major health insurer of overbilling the government for about $1 billion under the private plans.

Dr. James Taylor, a physician and coding expert who worked for Kaiser Permanente, was one of the whistle-blowers who flagged the overbilling. “The cash monster was insatiable,” he said.Credit...Rachel Woolf for The New York Times

By Reed Abelson and Margot Sanger-Katz - The New York Times
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Kaiser Permanente, the California-based health system, agreed to pay $556 million to the federal government and two whistle-blowers to settle civil lawsuits accusing it of fraudulent overbilling by its Medicare Advantage plans.

The two lawsuits, which were filed more than a dozen years ago, claimed that Kaiser overstated how sick its patients were to receive higher government payments.

The settlement sets a record dollar figure in a case involving Medicare Advantage, the controversial private plans that now cover more than half of those eligible for government health coverage, according to the Justice Department.

Lawmakers, government officials and some health care experts have repeatedly scrutinized abuses in the payment system for the private Medicare plans, as government fraud cases have been brought against numerous other insurers.

“Medicare Advantage is a vital program that must serve patients’ needs, not corporate profits,” said Craig H. Missakian, the U.S. attorney for the Northern District of California. “We have an obligation to protect the American taxpayer from waste, fraud, and abuse and we will relentlessly pursue individuals and organizations that compromise the integrity of the Medicare program.”

Kaiser did not admit wrongdoing in the settlement.

In the Kaiser case, executives routinely pressured doctors to add thousands of diagnoses, sometimes weeks or months after the patients had been treated, according to the Justice Department, which joined the lawsuits in 2021. The extra diagnoses helped the company earn bonus funds from the government, which pays higher insurance premiums to plans that cover sicker patients.

The doctors would sometimes sit together at lunch or after work, with food and drinks provided by Kaiser, to code their visits with additional diagnoses, the Justice Department lawsuit said. The suit says the insurer linked doctor and facility pay bonuses to adding more diagnoses.

According to the lawsuit, the government estimated that Kaiser received $1 billion from 2009 to 2018 from additional diagnoses, including roughly 100,000 findings of aortic atherosclerosis, or hardening of the arteries. But because its doctors would be forced to follow up on too many people, the organization stopped automatically enrolling those patients in a heart attack prevention program, the lawsuit said.

One of the whistle-blowers, Dr. James Taylor, a physician and coding expert who worked for Kaiser in Colorado, described meetings in which he was told to find additional diagnoses that could be worth millions of dollars. “The cash monster was insatiable,” he said.

In a statement published on its website but not attributed to a specific official, Kaiser said it had settled to avoid the cost and uncertainty of prolonged litigation.

“The Kaiser Permanente case was not about the quality of care our members received,” the statement said. “It involved a dispute about how to interpret the Medicare risk adjustment program’s documentation requirements.”

The settlement covers Kaiser-affiliated groups in California and Colorado.

Inspector general audits, scholarly studies, watchdog investigations and federal fraud suits have found that the kind of coding fraud alleged in the Kaiser case has been widespread throughout the industry. Five of the 10 largest insurers in the market have either settled a federal civil fraud suit or currently face one.

Just this week, Senator Chuck Grassley, Republican of Iowa, published a report accusing UnitedHealth Group, which owns the country's largest insurance company, of continuing to overbill Medicare by portraying its patients as sicker than they were.

"My investigation has shown UnitedHealth Group appears to be gaming the system and abusing the risk adjustment process to turn a steep profit," Mr. Grassley said in a statement.

UnitedHealth is also the target of a whistle-blower lawsuit, which the Justice Department joined in 2017, that accuses it of inappropriately increasing payments from the government. A special master appointed by the judge last year concluded that there was no evidence of fraud, but the case is continuing.

UnitedHealth defended its practices as lawful, saying they were approved by the federal Centers for Medicare and Medicaid Services, which oversees funding of the plans.

"Our programs comply with applicable C.M.S. requirements and have, through government audits, demonstrated sustained adherence to regulatory standards," the company said in a statement.

But Medicare Advantage remains a main focus for oversight, and the Justice Department has reached multimillion dollar settlements with Independent Health and Cigna within the last few years. Several lawyers who specialize in this area say the Trump administration has continued to pursue these cases, though staffing has declined.

"The government's ever increasing array of False Claims Act cases, spurred by whistle blowers, are an important backstop against abuse of this program, which now is used by a majority of America's Medicare beneficiaries," said Michael Ronickher, who is a partner at the law firm Whistleblower Partners, and one of Dr. Taylor's lawyers.

The Biden administration tried to crack down on this type of overbilling by reducing payments for some of the most overused diagnoses, a policy that is still being put in place after industry pushback slowed its adoption.

Trump administration officials have been more muted in their approach to the industry. Dr. Mehmet Oz, the administrator of the Centers for Medicare and Medicaid Services, has said that he thought the industry was ripe for reform. But the administration has not pursued any major new changes so far. Its next big Medicare Advantage regulation is expected in the coming weeks.

In an interview this week, Dr. Taylor said he was motivated to bring the suit by a "justice gene," and would be donating nearly all of his share of the payment to charity.

"The money doesn't vindicate me," he said. "Knowing people understand the wrongs that were committed makes me feel better."

Reed Abelson covers the business of health care, focusing on how financial incentives are affecting the delivery of care, from the costs to consumers to the profits to providers.

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